TODD M. SIGLER, PSYD, LP, NCC

REASON FOR THE REFERRAL FOR PSYCHOLOGICAL SERVICES?

☒	SERVICE REQUESTED	EXAMPLES	COVERED BY INSURANCE?
☐	TREATMENT & SERVICE PLANNING	Rule 185, Rule 79, CADI, DD, ASD, etc.	YES
☐	TO ASSESSMENT AN ATTENTIONAL PROBLEMS	ADHD, Dementia, Neurocognitive Disorder	YES
☐	HEALTH & BEHAVIOR ASSESSMENT PRIOR TO SURGERY	Bariatric or Spinal Cord Stimulator surgery.	YES
☐	APPLY FOR OR APPEAL A SOCIAL SECURITY DISABILITY	Social Security Hearing/Appeal	NO
☐	*COURT ORDERED PSYCHOLOGICAL EVALUATION*	Requested by court	NO
☐	HARDSHIP/BURDEN FOR DEPORTATION PROCEEDING	USCIS Proceeding	NO
☐	______________________	E.g., Academic, learning disability, etc.	TBD

PATIENT CONTACT INFORMATION

FIRST NAME: ______________________ LAST NAME: ______________________

GENDER: ____________ DATE OF BIRTH: ______________ PRIMARY PHONE #: ______________

EMAIL: ______________________ RACE/ETHNICITY: ______________ LANGUAGE: ______________

ADDRESS: ____

CITY: ______________________ STATE: ______________ ZIP: ______________

CONTACT INFORMATION FOR SCHEDULING APPOINTMENT & FOLLOW UP

WHO SHOULD I CONTACT TO SCHEDULE?: ______________________ RELATIONSHIP: ______________

EMAIL→ ______________________ PHONE: ______________ CELL ☐ WORK ☐ HOME ☐

OK TO CONTACT TO SCHEDULE APPOINTMENT AT/BY? (CHECK ALL THAT APPLY): CELL ☐ WORK ☐ HOME ☐ TEXT MSG ☐ EMAIL ☐ ALL ☐

REFERRAL AGENT INFORMATION

REFERRING AGENT (NAME/AGENCY): ______________________

ADDRESS: ______________________

FAX: ______________ PHONE: ______________ EMAIL: ______________

BACKGROUND AND MEDICAL INFORMATION

CURRENT DIAGNOSES: ______________________ ☐ (OR ATTACH RECORDS)

CURRENT MEDICATIONS: ______________________ ☐ (OR ATTACH RECORDS)

PRIMARY CARE PROVIDER: ______________________ ☐ (OR ATTACH RECORDS)

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: ______________ ID#: ______________ GROUP #: ______________

SECONDARY INSURANCE COMPANY: ______________ ID#: ______________ GROUP #: ______________

PATIENTS REQUIRING AN INTERPRETER

LANGUAGE: ______________ *INTERPRETER* GENDER PREFERENCE? MALE: ☐ FEMALE: ☐ NO PREFERENCE: ☐

NOTES/COMMENTS

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PLEASE FAX OR EMAIL THIS COMPLETED FORM TO DR. SIGLER USING THE CONTACT INFORMATION BELOW

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